

Fein Memory and Aging Center Clinic Referral Form

Thank you for choosing to refer your patient to the UCSF Fein Memory and Aging Center Clinic. To start the referral process, please fax this form and one year of medical records, lab work, and copy of both sides of your insurance card to our office at 415.353.8292 and mail a copy of your MRI scan to the address above. For additional information, visit our website at memory.ucsf.edu/services/referral.

Date: _____

Name of patient: _____ Date of birth: _____

Home address: _____

Home phone: _____ Cell phone: _____

Primary language: _____ Interpreter needed: Yes No

Name of primary contact person involved in care (for example, a family member): _____

Address: _____

Home phone: _____ Cell phone: _____

Insurance carrier, PPO/HMO, and subscriber number: _____

Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

PCP name: _____

Phone: _____ Fax: _____

Reason for Referral

URGENT? (prion disease, rapidly progressive dementia or encephalitis?) Yes No

Clinical question to be answered, please be specific: _____

Records (include one year of medical records, lab work and MRI results)

Has the patient completed neuropsychology testing prior to referral? Yes No
(If yes, please include report)

Has the patient had brain imaging within the last 2 years? Yes No Please mail disc or push to Life Image

Insurance authorization complete? Yes No

An appointment will not be scheduled without authorization. Please refer to our referral checklist for codes required.